MOTION FILED

MAR 2 0 1997

(4)

No. 96-1365

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1996

VALERIE MILLER, *et al.*,
*Petitioners,*

v.

ARLENE M. BROWN, M.D., *et al.*,
*Respondents.*

**On Petition for Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit**

## MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

FREDRIC J. ENTIN
JAMES A. HENDERSON
MARGARET J. HARDY
AMERICAN HOSPITAL ASSOCIATION
One North Franklin
Chicago, Illinois 60606
(312) 422-3000

R. HEWITT PATE *
VIRGINIA H. HACKNEY
HUNTON & WILLIAMS
Riverfront Plaza, East Tower
951 East Byrd Street
Richmond, Virginia 23219
(804) 788-8200

March 20, 1997

* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

23 pp

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1996

---

No. 96-1365

---

VALERIE MILLER, *et al.*,
*Petitioners,*

v.

ARLENE M. BROWN, M.D., *et al.*,
*Respondents.*

---

**On Petition for Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit**

---

## MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

---

The American Hospital Association hereby respectfully moves for leave to file the attached brief *amicus curiae* in support of petitioners in the above-styled case. Counsel for petitioners have consented to the filing of the brief. The consent of counsel for the respondents was requested but refused.

The American Hospital Association is the primary organization of hospitals in the United States. Its membership includes 70% of the Nation's 5,000 hospitals, health systems, and other health care institutions, as well as approximately 38,000 personal members. The Association has a vital interest in the interpretation of the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101 *et seq.* ("HCQIA") that is at issue in this peti-

tion. HCQIA's provisions protecting "peer review" proceedings are critical to the ability of the Association's member hospitals to ensure quality health care for their patients.

The American Hospital Association serves a nationwide constituency of interested hospitals and health care providers. The Association has closely monitored judicial interpretations of HCQIA and participated as *amicus curiae* in a number of cases. Accordingly, the American Hospital Association respectfully submits that it is able to offer a broader perspective on the nationally important issues raised by the petition than can be provided by the parties alone.

WHEREFORE, the American Hospital Association respectfully requests that the Court grant leave for the filing of the attached brief *amicus curiae*.

Respectfully submitted.

FREDRIC J. ENTIN
JAMES A. HENDERSON
MARGARET J. HARDY
AMERICAN HOSPITAL ASSOCIATION
One North Franklin
Chicago, Illinois 60606
(312) 422-3000

R. HEWITT PATE *
VIRGINIA H. HACKNEY
HUNTON & WILLIAMS
Riverfront Plaza, East Tower
951 East Byrd Street
Richmond, Virginia 23219
(804) 788-8200

* Counsel of Record

March 20, 1997

TABLE OF CONTENTS


| | Page |
|---|---|
| STATEMENT OF INTEREST OF THE *AMICUS CURIAE* | 1 |
| SUMMARY OF ARGUMENT | 2 |
| ARGUMENT | 4 |
| I. HCQIA'S IMMUNITY AND REPORTING PROVISIONS ARE VITAL TO PROTECTING PUBLIC HEALTH THROUGH VIGOROUS PEER REVIEW | 4 |
| II. THE DECISION BELOW CREATES A SPLIT OF AUTHORITY THAT THREATENS TO UNDERMINE PEER REVIEW AND PATIENT SAFETY | 9 |
| III. THE TENTH CIRCUIT'S DECISION REPRESENTS A SERIOUS THREAT TO THE NATIONAL DATA BANK THAT MERITS THE COURT'S ATTENTION | 13 |
| CONCLUSION | 17 |

## TABLE OF AUHORITIES


Cases — Page

*Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992) ..... 3, 9, 10
*Bigman v. Medical Liability Mutual Insurance Co.*, 1996 WL 79330 (S.D.N.Y. February 22, 1996) .. 15
*Bose Corp. v. Consumers Union of U.S., Inc.*, 466 U.S. 485 (1984) ..... 16
*Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 1363 (1995) ..... 9
*Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966) ..... 4
*Fobbs v. Holy Cross Health System Corp.*, 789 F. Supp. 1054 (E.D. Cal. 1992), *aff'd in part*, 29 F.3d 1439 (9th Cir. 1994) ..... 12
*Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026 (4th Cir. 1994) ..... 9
*Malley v. Briggs*, 475 U.S. 335 (1986) ..... 13
*Mathews v. Lancaster General Hosp.*, 87 F.3d 624 (3d Cir. 1996) ..... 9
*The Santisima Trinidad*, 7 Wheat. 283 (1922) ..... 16
*Time, Inc. v. Pape*, 401 U.S. 279 (1971) ..... 16

Statutes, Regulations, and Legislative Materials

Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101 *et seq.* ("HCQIA") ..... *passim*
45 C.F.R. § 60.4 ..... 6
45 C.F.R. § 60.14 ..... 15
H.R. Rep. No. 903, 99th Cong., 2d Sess. 2-3 *reprinted in* 1986 U.S. Code Cong. & Admin. News 6385 ..... 6, 9
*Medical Malpractice: Hearings on H.R. 5110 Before the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce*, 99th Cong., 2d Sess. 308 (1986) ..... 6
Health Resources & Services Admin., U.S. Dept. of Health & Human Servs., *National Practitioner's Data Bank Guidebook* (1996) ..... 6

TABLE OF AUTHORITIES—Continued


| Miscellaneous | Page |
|---|---|
| American Hospital Association/American Medical Association, *Report of the Joint Task Force on Hospital Medical Staff Relationships* II (1985) | 5 |
| Comment, *The Health Care Quality Improvement Act of 1986: A Proposal for Interpretation of Its Protection*, 20 St. Mary's L.J. 955 (1989) | 9 |
| Curran, *Law-Medicine Notes: Medical Peer Review of Physician Competence and Performance: Legal Immunity and the Antitrust Laws*, 316 New Eng. J. Med. 597 (1987) | 5 |
| Note, *The Health Care Quality Improvement Act of 1986: Will Phyqsicians Find Peer Review More Inviting?*, 74 Va. L. Rev. 1115 (1988) | 6 |
| Peer Review Immunity Task Group of the American Academy of Hospital Attorneys of the American Hospital Association, *Immunity For Peer Review Participants in Hospitals: What Is It? Where Does It Come From? How Do You Protect It?* (1989) | 5 |
| Southwick & Slee, *Quality Assurance in Health Care: Confidentiality of Information and Immunity for Participants*, 5 J. Legal Med. 343 (1984) | 4 |

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1996

---

No. 96-1365

---

VALERIE MILLER, *et al.*,

*Petitioners,*

v.

ARLENE M. BROWN, M.D., *et al.*,

*Respondents.*

---

**On Petition for Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit**

---

## BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

---

### STATEMENT OF INTEREST OF THE *AMICUS CURIAE*

The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. The AHA's mission is to advance the health of individuals and communities. AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement. Its membership includes 70% of the Nation's 5,000 hospitals, health systems, and other providers of care. Over 38,000 health care professionals hold individual memberships in the AHA. Through participation here, AHA seeks to further the "overriding national need" for effective physician

peer review expressed by the Congress in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101 *et seq.* ("HCQIA").

Peer review is a vital means by which hospitals can protect patients from physicians who are incompetent or who engage in unprofessional behavior. Effective peer review can be jeopardized by the threat of retaliatory litigation brought by physicians whose clinical privileges or staff memberships have been adversely affected. HCQIA is intended to reduce this risk by providing peer review participants with immunity from suits for money damages. By promoting effective peer review and instituting a reporting system for peer review actions, HCQIA is intended to protect patient health and safety nationwide.

AHA's hospital and health care provider members share a keen interest in ensuring that judicial construction of HCQIA takes into account the importance to patients of peer review and the crucial role HCQIA's immunity plays in encouraging successful peer review. Congress recognized in adopting HCQIA that the practice of incompetent physicians cannot be curtailed unless those willing to participate in peer review are protected by immunity from the threat of resulting litigation. Judicial construction of the statute that undermines this protection is therefore a matter of grave concern to the AHA and its members.

## SUMMARY OF ARGUMENT

The peer review immunity provisions of HCQIA are vital to the safety of patients nationwide. Only effective immunity can provide physicians—who alone possess the skills to evaluate their peers—with the protection that allows them to participate in peer review. Only peer review allows HCQIA's national reporting system to prevent the continued practice of incompetent or unprofessional physicians. In short, Congress recognized in passing HCQIA that peer review immunity is an important keystone on which quality health care depends.

Achievement of HCQIA's purposes requires faithful judicial application of the objective standard of review and the presumption in favor of immunity provided by the statute. This means that a plaintiff should not be able to subject peer reviewers to a jury trial for money damages unless the plaintiff has produced affirmative evidence that would allow a jury to determine that no reasonable peer reviewer could have reached the conclusion at issue in the "reasonable belief that the [action] was warranted by the facts known after a reasonable effort to obtain facts." *Austin v. McNamara*, 979 F.2d 728, 735 (9th Cir. 1992).

In conflict with other courts of appeals that have addressed HCQIA's immunity provisions to date, the court below rejected the principle that peer reviewers are entitled to immunity as a matter of law where the record establishes that the action taken was among those that a reasonable peer reviewer could have taken, without regard to whether the court or jury might itself have reached a different conclusion. The opinion below instead endorses an approach that subjects peer reviewers to the risk that juries will second-guess their medical judgments in damages suits, directly contrary to congressional intent. The chilling effect on peer review created by this approach threatens a degree of harm to national health care safety that merits the Court's attention.

The second important aspect of the court of appeals' opinion—affirming a judgment for defamation based upon the completion of a box with a code number on the standard form for reporting adverse action to the National Practitioner Data Bank—also presents a serious threat to the national system for protecting patient safety that HCQIA created. Peer reviewers are *required* to report certain adverse actions to the National Practitioner Data Bank, and required to do so on a standard form. Here the court below allowed imposition of *damages based upon the selection* of a reporting category that was plainly a reasonable choice under the circum-

stances. The decision below is irreconcilable with this Court's understanding of the meaning of "knowing falsity," the applicable standard for immunity under HCQIA. The Court's attention is warranted to protect the vitality of our national health care safety information system.

## ARGUMENT

### I. HCQIA'S IMMUNITY AND REPORTING PROVISIONS ARE VITAL TO PROTECTING PUBLIC HEALTH THROUGH VIGOROUS PEER REVIEW

The foundation of HCQIA's protection of patient health and safety is the system of "medical peer review." Peer review involves "setting standards of care, reviewing cases to determine whether the standards are being met, recommending and implementing methods to improve substandard care, and subsequent reviews of care to determine whether goals have been achieved." *See* Southwick & Slee, *Quality Assurance in Health Care: Confidentiality of Information and Immunity for Participants*, 5 J. Legal Med. 343, 346 (1984). It is through the constant scrutiny of the peer review process that patients are protected from substandard care through the imposition of monitoring and consultation requirements or, ultimately, through formal disciplinary action such as a reduction, suspension, or termination of clinical privileges or staff membership.

Effective peer review is not only a vital aspect of every hospital's ethical duty to protect the public health; it is a legal necessity. Hospitals are bound by law to ensure that only qualified physicians are allowed to treat patients. *See, e.g., Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966) (the seminal opinion on hospital "corporate negligence"). State laws and regulations may also impose peer review requirements directly. *See, e.g.*, Cal. Code Regs. tit. 22 § 70703. In addition, peer review procedures are mandated by national accrediting bodies such as the Joint Commission on the Accredita-

tion of Healthcare Organizations (JCAHO). *See* JCAHO, Comprehensive Accreditation Manual for Hospitals; The Official Handbook (1/1/97), Ms. 2.3.3, Ms. 5.7, Ms. 5.8. In short, medical ethics, state law, and the Nation's major hospital accrediting authority all make peer review essential to delivering quality health care.

Physicians' voluntary service in peer review programs is indispensable to protecting the quality of care, for only physicians possess the "particular skills and judgment" necessary for assessing and analyzing the quality of care rendered in a hospital. See American Hospital Association/American Medical Association, *Report of the Joint Task Force on Hospital-Medical Staff Relationships* II (1985). Unfortunately, doctors know that one likely consequence of participation on peer review committees is the threat of litigation. Litigation—especially antitrust litigation, with its potential for complexity, high litigation costs, and treble damages—is a fearsome disincentive to service as a peer reviewer. *See* 42 U.S.C. § 11101 (finding of Congress). Without HCQIA immunity none but the most resolute physicians would agree to participate in peer review.[1]

With the passage of HCQIA, Congress moved to bolster peer review systems and to address shortcomings

[1] Sanctioned physicians often retaliate against their peer reviewers with a legal blunderbuss. Possible causes of action include defamation, antitrust, discrimination, malpractice, due process, equal protection, breach of contract, tortious interference with contractual or business relationships, intentional infliction of emotional distress, and claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"). *See* Peer Review Immunity Task Group of the American Academy of Hospital Attorneys of the American Hospital Association, *Immunity For Peer Review Participants in Hospitals: What Is It? Where Does It Come From? How Do You Protect It?* 72-75 (1989). Physicians themselves are well aware that this type of litigation is usually complex, expensive, and hard fought. *See* Curran, *Law-Medicine Notes: Medical Peer Review of Physician Competence and Performance: Legal Immunity and the Antitrust Laws*, 316 New Eng. J. Med. 597 (1987).

that required national solutions. Prior to the passage of HCQIA, reporting of physician incompetence was the province of state licensing boards. Unfortunately, both the definition of offenses and the standards for dealing with them varied from state to state. *See, e.g., Medical Malpractice: Hearings on H.R. 5110 Before the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce*, 99th Cong., 2d Sess. 308 (1986) (statement by Richard P. Kusserow, Inspector General, Department of Health and Human Services). Because state licensing and reporting systems were not centralized and uniform information was not available, incompetent physicians could move easily from state to state, often "plea bargaining" an arrangement allowing them to resign staff privileges or credentials and depart before formal hospital or state licensure action was taken. *See* H.R. Rep. No. 903, 99th Cong., 2d Sess. 2-3 *reprinted in* 1986 U.S. Code Cong. & Admin. News 6385.

HCQIA was passed to address these problems. It does so not only by protecting the physicians involved in peer review, but also by establishing "a comprehensive, nationwide system to prevent physicians who have been identified as incompetent by one hospital from simply relocating and resuming their practice in another." Note, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 Va. L. Rev. 1115, 1125-26 (1988). HCQIA accomplishes this through the operation of the National Practitioner Data Bank ("NPDB" or "Data Bank"). Hospitals, as well as insurers and other health care entities and state boards of medical examiners, are required to report adverse credentialing actions and medical malpractice payments to the Data Bank. *See* 45 C.F.R. Part 60. They are required to use a standard form for making reports. 42 U.S.C. § 11134; 45 C.F.R. § 60.4; Health Resources & Services Admin., U.S. Dept. of Health & Human Servs., *National Practitioner's Data Bank Guidebook* (1996), Section E and Appendix A [hereinafter "*Guidebook*"]. Hospitals or

health care entities that fail to follow the reporting requirements of HCQIA may lose their immunity for three years. 42 U.S.C. § 11133(c). Hospitals are required to request information from the Data Bank when they receive an application for privileges. 42 U.S.C. § 11135. Thus, reported problems a physician has at one hospital will be known to any other hospital where he or she applies for privileges. The importance of this system to the public health is self-evident. But it cannot function without physician participation in peer review and hospital support.

HCQIA reflects Congress' recognition that peer reviewers' fears of protracted and expensive lawsuits by disgruntled physicians could jeopardize national health care safety. Congress set forth the following reasons for enacting HCQIA:

> (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state.
>
> (2) There is a national need to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of the physician's previous damaging or incompetent performance.
>
> (3) This nationwide problem can be remedied through effective professional peer review.
>
> (4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
>
> (5) There is an *overriding national need* to provide incentive and protection for physicians engaging in effective professional peer review.

42 U.S.C. § 11101 (emphasis added). By setting forth these reasons, Congress confirmed the "national need" to provide incentives and protection for peer reviewers.

HCQIA's immunity provision, 42 U.S.C. §§ 11111-11115, grant peer reviewers immunity from damages under both federal and state law where peer review actions are taken:

> (1) In the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) After a reasonable effort to obtain the facts of the matter,
>
> (3) After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances,[2] and
>
> (4) In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph 3.

42 U.S.C. § 11112(a).[3]

HCQIA explicitly provides that its immunity provisions are *presumed* to apply where peer reviewers assert them. By imposing an *objective* standard by which to judge claims of qualified immunity and by imposing a presumption that the immunity applies, Congress codified its intent that HCQIA claims be resolved as a matter of law.

---

[2] HCQIA provides a list of procedural measures which, if followed, will be *deemed* to show compliance with this third immunity standard. The failure of an institution to employ all of these measures does not, however, deprive the hospital of immunity. *See* 42 U.S.C. § 11112(b) (last sentence). In addition, HCQIA explicitly provides for *immediate* suspension or restriction of privileges, without prior notice and hearing, "where the failure to take such an action may result in an imminent danger to the health of any individual." 42 U.S.C. § 11112(c)(2) (emphasis added).

[3] HCQIA immunity is limited to private damages actions, and does not prevent suits by federal or state governments under the Clayton Act or other provisions. HCQIA immunity is also inapplicable to civil rights suits, and raises no bar to plaintiffs seeking injunctive relief or declaratory judgments. 42 U.S.C. § 11111(a)(1).

Originally, Congress considered a subjective "good faith" standard, which would have required evidence of the defendant's subjective state of mind, an inquiry that could only be resolved by a jury. But this subjective standard was changed to the objective, "reasonable belief" test, which inquires into what the reviewers would reasonably have concluded, and not why they so concluded. H.R. Rep. No. 903, 99th Cong. 2d Sess. 10, *reprinted in* 1986 U.S. Code Cong. & Admin. News 6394. By setting this objective standard, and by allowing judges to rule on the presumption of immunity as a matter of law, Congress intended prompt, uniform, and early judicial disposition of HCQIA cases. *See* Comment, *The Health Care Quality Improvement Act of 1986: A Proposal for Interpretation of Its Protection*, 20 St. Mary's L.J. 955, 976 (1989).

## II. THE DECISION BELOW CREATES A SPLIT OF AUTHORITY THAT THREATENS TO UNDERMINE PEER REVIEW AND PATIENT SAFETY

Prior to the decision below, courts have recognized that evaluation of HCQIA immunity does not involve a post hoc review with 20/20 hindsight, asking whether the action taken was "correct" or was the "best" course available. As the Ninth Circuit stressed in *Austin v. McNamara*, 979 F.2d 729 (9th Cir. 1992), there may frequently be evidence that might "call into question the ultimate reasonableness" of the action taken against a physician. *Id.* at 735. *But*, as that Court aptly put it: "That is a different question of 'reasonableness,' however, than the issue whether the defendants acted in the 'reasonable belief that the [suspension] was warranted by the facts known after reasonable effort to obtain facts' as required by Section 11112(a)(4)." *Id.* Other courts of appeals have similarly applied HCQIA's objective standard with due regard for the presumption of immunity. *See Mathews v. Lancaster General Hosp.*, 87 F.2d 624, 635 (3d Cir. 1996); *Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026, 1030 (4th Cir. 1994); *Bryan v. James E.*

*Holmes Regional Medical Center*, 33 F.3d 1318, 1323 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 1363 (1995).

The facts and holding in *Austin* could hardly provide a starker contrast to the unfortunate holding below. Following the suspension of the plaintiff's privileges in *Austin*, the hospital's own Judicial Review Committee ("JRC") explicitly announced its disagreement with the decision and recommended that privileges be restored, stating that "the preponderance of the evidence favors Dr. Austin and . . . [that] the recommendation of the Medical Executive Committee was not reasonable and warranted and that the clinical privileges of Dr. Austin should not be revoked." *Id.* at 735. Notwithstanding this evidence, the Ninth Circuit concluded following a review of the entire JRC report that "no reasonable jury could find that the JRC report is sufficient to establish the nonexistence of defendants' 'reasonable belief' and 'reasonable effort' " under HCQIA standards. *Id.* at 735.

The Ninth Circuit's opinion in *Austin* is impossible to reconcile with the decision below. Here the respondent physician herself acknowledged that the conclusion reached by the peer reviewers was "one conclusion that could have been reached, but not the only one." Pet. 10. Notwithstanding this evidence, the Tenth Circuit upheld a jury damages verdict based solely upon the testimony of respondents' expert, Dr. Lindley. App. 20. The Tenth Circuit was quite explicit in rejecting the approach that had mandated entry of judgment for the defendants in *Austin*:

> According to the defendants, a "difference of opinion among experts" does not raise an issue as to the objective reasonableness of the inquiry. We are not persuaded by the defendant's view.

App. 20 at n.9. The approach adopted by the court below is in fact the approach advocated by the *dissent* in *Austin*, in which the jury is called upon to choose among

competing medical conclusions. *See* 979 F.2d at 741-42 (Pregerson, J., dissenting).

Contrary to the erroneous suggestion raised by respondents, Opp. 9, the severity of the circuit split created by the erroneous decision below cannot be lessened by characterizing it as a decision about a "separate" statutory standard relating to the "reasonable effort" to gather facts called for by 42 U.S.C. § 11112(a)(2). The court of appeals plainly did not distinguish among HCQIA's "reasonableness" standards in rejecting the objective approach of the other circuits. *See* App. 20 n.9. There is no basis upon which the court could have done so, for operation of this presumption applies in the same manner to *all four* statutory standards.

As originally proposed, the HCQIA presumption was to apply only to the first standard listed in 42 U.S.C. 11112(a), *i.e.*, that the professional review action was taken in the furtherance of quality health care. But Congress emphasized its desire for early resolution of immunity claims by changing the statute to apply the presumption to all four standards:

> *All four standards are now treated similarly.* The standard concerning whether the action was in furtherance of the quality of care still has the benefit of a presumption, but now that presumption is to be overcome by a preponderance of the evidence. *Similarly, the amendment now makes clear that the burden of proof with respect to the other three standards is the same as that for subsection 102(a)(1) and rests on the plaintiff*, not the defendant or defendants.

132 Cong. Rec. H9954, H9959 (daily ed. Oct. 14, 1986) (statement of Rep. Waxman) (emphasis added). In practical application, the standards in fact become part of the same inquiry. Contrary to respondents' statement that no prior decision dealt with the "reasonable effort" standard, the *Austin* court described the relevant question as whether the action taken was "warranted by the facts

known *after reasonable effort to obtain the facts.*" 979 F.2d 728 (emphasis added). So too, here, the ultimate conclusion of the doctors who testified that the peer reviewers' actions were reasonable obviously included the subsidiary conclusion that they were based upon adequate facts.

Subjecting peer reviewers to second-guessing by juries based upon the argument that more medical records should have been reviewed is particularly pernicious. Any lawyer with experience in peer review cases will recognize the hackneyed argument that—notwithstanding the errors in a specific case—a physician can only be judged fairly if a much larger body of work is reviewed. In the complex context of peer review, the argument is a particularly dangerous one, for it raises endless questions over how many records to review and how to select them. HCQIA was meant to relieve doctors from the threat that peer review will leave them open to liability unless they make choices with which no other expert will disagree or engage in a time consuming review of the subject doctors' life's work entailing endless hours away from the reviewers' own medical duties. *See Fobbs v. Holy Cross Health System Corp.*, 789 F. Supp. 1054, 1066 (E.D. Cal. 1992), *aff'd in relevant part*, 29 F.3d 1439 (9th Cir. 1994) (rejecting claim that "the number of cases initially investigated and upon which the monitoring restraints were imposed, four, was too small"). Yet this is exactly the threat to peer review given judicial endorsement by the decision below.

This Court should grant certiorari and give clear guidance that HCQIA's objective standard affords immunity unless *no physician* would reasonably believe from the facts that he or she was acting in furtherance of quality health care or that the action taken was warranted by the facts. Under a proper application of the objective standard as interpreted by the Third, Fourth, Ninth, and Eleventh Circuits, the fact that there is often more than one manner in which to handle a particular peer review situa-

tion provides no basis for concluding an action is unreasonable. Contrary to the suggestion of respondents and the court below, this would not amount to "absolute immunity" for peer reviewers, but instead would reflect a proper application of qualified immunity standards with which the Court has long been familiar in other contexts. Cf. *Malley v. Briggs*, 475 U.S. 335, 341 (1986) (to be effective, qualified immunity must protect decisions over which decisionmakers "of reasonable competence could disagree").

## III. THE TENTH CIRCUIT'S DECISION REPRESENTS A SERIOUS THREAT TO THE NATIONAL DATA BANK THAT MERITS THE COURT'S ATTENTION

The second aspect of the decision below—affirmance of a judgment for defamation based upon the completion of a box with a code number on the standard National Practitioner Data Bank reporting form—presents an equally serious threat to the system of medical safety information created by HCQIA. HCQIA requires health care entities to report the actions of peer reviewers to the National Practitioner Data Bank. Moreover, the applicable requirements specify the form upon which such a report must be made and require a health care entity employee to choose from among numbered codes to classify the peer review action taken. *See Guidebook*, Appendix A (*see also*, Adverse Action Report Forms and Instructions).

In this case, the available choices on the reporting form were as follows:

Revocation—Clinical Privileges

610.01 Alcohol and Other Substance Abuse
610.02 Incompetence/Malpractice/Negligence
610.03 Narcotics Violations
610.04 Felony
610.10 Unprofessional Conduct
610.20 Medical Disorder
610.30 Allowing Unlicensed Persons to Practice

610.50 Disciplinary Action Taken in Another State
610.80 Physical Impairment
610.90 Other

Pls. Ex. 62. In the circumstances presented here—failure to obtain a required consultation before treating a type of patient whom the physician had agreed not to treat without consultation because of questions raised about her competence to do so—petitioners chose classification number 610.02, "Incompetence/Malpractice/Negligence."

As the court below acknowledged, HCQIA precludes liability based upon the filing of a Data Bank adverse action report "unless there is sufficient evidence for a jury to conclude the report was false and the reporting party knew it was false." App. 21, *citing* 42 U.S.C. § 11137(c). The court below subjected the hospital's employee here to damages liability based upon a highly formalistic analysis: because the peer review committee had never issued a formal judgment of "incompetence/malpractice/negligence," (*i.e.*, in just those words) it was therefore "knowingly false" for defendants to select this code number on the standard reporting form. App. 22. Unless corrected by this Court, this hypertechnical approach to liability for Data Bank reporting will severely chill the willingness of hospital employees to submit the reports upon which the Data Bank is built.

The choice of classification 610.02 was plainly a reasonable alternative under any fair understanding of the "knowing falsity" standard. As the court of appeals acknowledged, the peer reviewers here had concluded that the respondent physician was competent to handle *low risk* obstetrical patients, but had exacted a promise from her due to concerns about her competence that she would not treat high risk obstetrical patients without obtaining a consultation. App. 4, 22. Notwithstanding her promise made following questions about her competence to care for high risk obstetric patients without a consult, respondent did just that—she treated high risk patients without obtaining the consultation as agreed. In other words, re-

spondent treated patients without consultation whom she had agreed at the hospital's insistence not to treat without a consultation due to questions about her competence to do so. In this situation, the selection of a classification of "Incompetence/Malpractice/Negligence" surely cannot be described as a "knowingly false" choice. At most, it reflects a debatable choice among available alternatives to describe an ambiguous situation.

Moreover, in filling out the report form, the hospital's employee gave a clear and accurate description of the basis for the action taken: "failure to obtain mandatory consults on high risk obstetrics." Pl. Ex. 62. Given the choices available upon the standard reporting form and the fact that the hospital employee gave a full and accurate description of the basis for the action, it is difficult to imagine what more she was supposed to have done. It is a truism of defamation litigation that a statement must be viewed in context as a whole. Here, however, the Tenth Circuit affirmed a judgment for defamation under HCQIA's more protective standards based upon a form that was undeniably accurate.[4]

The standard upon which the court purported to uphold liability against the defendants—"knowing falsity"—is one that this Court in other defamation contexts has found to give a high degree of protection to speakers. For example, in *Time, Inc. v. Pape*, 401 U.S. 279 (1971), the Court held that actual malice—which requires the *lesser* showing of knowledge of falsity *or* recklessness as to falsity—could not be shown from the omission of the word "alleged" in

---

[4] Imposition of liability for defamation was particularly improper here, where respondent had failed to pursue her administrative remedies to have the Report reviewed for accuracy by the Secretary of Health and Human Services. *See* 45 C.F.R. § 60.14. One Court has in fact held that subject matter jurisdiction over a claim based upon Data Bank reporting is lacking where the plaintiff has not exhausted the administrative remedies provided by HCQIA. *See Bigman v. Medical Liability Mutual Insurance Co.*, 1996 WL 79330 (S.D.N.Y. February 22, 1996).

reporting charges of police brutality. While the omission could be said to make the statement at issue false in a technical sense, the omission

> amounted to the adoption of one of a number of possible rational interpretations of a document that bristled with ambiguities. The deliberate choice of such an interpretation, though arguably reflecting a misconception, was not enough to create a jury issue of "malice" under *New York Times.*

*Id.* at 289-90.

Similarly, in *Bose Corp. v. Consumers Union of U.S., Inc.*, 466 U.S. 485 (1984), the defendant reviewer was sued for product defamation. He had written that instruments heard through the plaintiff's loudspeakers appeared to "move about the room." The defendant conceded, however, that in fact he had observed the sounds moved "along the wall"—not "about the room"—a significant difference for purposes of evaluating a loudspeaker. This Court affirmed the court of appeals' entry of judgment in favor of the defendant on the ground that the burden of showing knowledge of falsity had not been met:

> The trial court took him at his word, and reasoned that since he did know what he had heard, he must have realized the statement was inaccurate at the time he wrote it. "Analysis of this kind may be adequate when the alleged libel purports to be an eyewitness or other direct account *of events that speak for themselves.*" *Time, Inc. v. Pape*, 401 U.S., at 285. See generally *The Santisima Trinidad*, 7 Wheat. 283, 338-339 (1822). Here, however, adoption of the language chosen was "one of a number of possible rational interpretations" of an event "that bristled with ambiguities" and descriptive challenges for the writer. *Time v. Pape, supra*, at 290. The choice of such language, though reflecting a misconception, does not place the speech beyond the outer limits of the First Amendment's broad protective umbrella.

*Id.* at 512-13.

The "broad protective umbrella" of the actual malice standard that the Court addressed in *Bose* is in fact *less protective* than the strict "knowing falsity" standard Congress adopted in HCQIA to protect hospital employees who must assign a Data Bank reporting description to complicated events that necessarily "bristle with ambiguities." Here, however, the court below applied a crabbed reading of HCQIA that deprived the individual completing the report of the protection to which she was entitled. Affirmance of a judgment for defamation in these circumstances represents a serious threat to the willingness of all involved to participate in reporting to the National Practitioner Data Bank. Given the clear conflict of this decision with this Court's prior interpretations of "knowing falsity" and the potential consequences for health care safety, review by the Court is warranted.

## CONCLUSION

For the foregoing reasons, *amicus* AHA respectfully submits that the petition should be granted.

Respectfully submitted,

FREDRIC J. ENTIN
JAMES A. HENDERSON
MARGARET J. HARDY
AMERICAN HOSPITAL ASSOCIATION
One North Franklin
Chicago, Illinois 60606
(312) 422-3000

R. HEWITT PATE *
VIRGINIA H. HACKNEY
HUNTON & WILLIAMS
Riverfront Plaza, East Tower
951 East Byrd Street
Richmond, Virginia 23219
(804) 788-8200

* Counsel of Record

March 20, 1997